Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005077	A. BUILDING _____ B. WING _____	11/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEARBORN COUNTY HOSPITAL	600 WILSON CREEK RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of a State complaint. Complaint: IN00085218 Unsubstantiated, lack of sufficient evidence. Date of Survey: 11-01-11 Facility number: 005077 Surveyor: John Lee, R.N. Public Health Nurse Surveyor Dearborn County Hospital is in compliance with 410 IAC 15-1.6-2, Emergency services, Hospital Licensure Rules. QA: claughlin 11/15/11	S 000		